

Interview with Dr. Arthur McFee, surgeon aboard USS *Repose* (AH-16) and head of the hospital ship's Intensive Care Unit, 1966. Conducted by Jan K. Herman, Historian of the Navy Medical Department, 19 July 2005.

Where are you originally from?

I was born in Portland, ME, in 1932. I went for 8 years to Harvard, and for 8 years to the University of Minnesota for surgical training.

When was that?

I entered Harvard in 1949, medical school in 1953, the University of Minnesota in 1957, and the Navy in 1965.

Why the Navy?

That sort of gets to why I went to the *Repose*. I was a Berry Plan member in those years which guaranteed you the completion of your residency if you enrolled and opted to pick the branch of service that you wanted. I picked the Navy simply because my father had been in the Navy and I had grown up in Portland, ME. There was a fair experience with the Navy there.

Casco Bay had quite a fleet there during the war.

It certainly did and a big shipbuilding enterprise.

So the maritime tradition was just in your blood.

I enjoyed things maritime and I think it was a good choice. My assignment to the *Repose* is a small story in itself. I, as a Berry Planner, was a U.S. Naval Reserve officer. I found out very quickly when I arrived on the *Repose* that it was probably the choice assignment for anybody in the Navy Medical Corps because it had been a pet project of Admiral Robert Brown who was the then Surgeon General. It happened, as with most Berry Planners, that you had to complete a form in your residency training each year to certify that you were still in training. I missed the form in 1963. They were simply mimeographed papers the Bureau sent out.

I entered my senior residency on November 1, 1964; and I entered on the senior resident post at Minnesota on 1 March 1965, which was Dr. Wangenstein's service. He was the chairman of the department. In May or June, I received three sets of orders from the Navy to report for duty on the East Coast, the West Coast, and Okinawa--all in one week!

All three?

All three. I took them to Dr. Wangenstein and he said, "I don't think you should go anywhere because it's obvious that they don't know where you're going to go." There ensued a fair amount of discussion between our department and the Bureau of Medicine and Surgery.

On a morning in June, a week before I was supposed to report to Okinawa, Dr. Wangenstein called me in and said, "Who do I call?" This was after 6 weeks of getting nowhere with the bureaucracy. I said, "The only person I think we haven't talked to is Admiral Brown, the Surgeon General."

He said, "Admiral Brown! I know Bob."

So he called Admiral Brown and asked him about his wife and children and things like that. I listened to this conversation. And then he said, "Your boys have got their hands on one

of my men.” And the clincher was, “Well, he’s my senior resident and it would be inconvenient for him to go now. But it would be a greater inconvenience to me.”

The background of this conversation was . . . and this was in 1965 . . . Dr. Wangenstein had been President of the American College of Surgeons in ’61 or ’62. Admiral Brown would have given his eye teeth to have been President of the American College of Surgeons.

Admiral Brown was a renowned surgeon.

He was and also a very nice man. About 4 days later, I received 400 copies that said, “Orders to active duty canceled.” About 8 or 9 months later while I was finishing my Ph.D., I got a personal letter from Admiral Brown saying that they were thinking of bringing me back into the service now and deploying me in the Far East.

It wasn’t until I arrived on the ship that I found out what a choice assignment it was. Someone said to me, “How did you get on this ship? You’re USNR, not regular Navy.” This was almost one of the only times in my life when, without any effort, I was one up on everybody. I told him I had simply opened the orders and that’s what they said to do. It was a fascinating time and, actually, it got to be a bit embarrassing until the chest surgeon took me aside one day after we left San Francisco and said, “I really have to tell you, Arthur, not everyone comes into the Navy with a personal letter from the Surgeon General.” All this inaugurated probably one of the most enjoyable years of my life.

Did you have any orientation into the Navy? Did you end up going to Newport?

I left Minnesota in very late November, 1965 and I went to take the first part of the surgical boards with a friend of mine in New Orleans. I stayed a couple of days with him and then went to Oakland. The ship was laid up at Hunter’s Point in San Francisco in preparation to sail.

I had received probably 10 sets of orders postponing the day of sailing from May thru November. At Oakland, I was given probably four 1-hour sessions a week for 2 weeks to indoctrinate me into the basics of the Navy; and they were really basic: “The pointy end of the ship is the bow and the roundy end is the stern;” Don’t jump off the stern because the propellers are there.” Well, I couldn’t swim and had no intention of doing it anyway. It was really rudimentary, but a one-on-one introduction given by a rather senior petty officer at Oakland.

The 3 weeks I spent at Oakland gave me the opportunity to finish my Ph.D. thesis. During the week of Christmas, my fiancée came out and we enjoyed San Francisco until the ship left on the 2nd of January of ’66.

What was your impression of seeing that big white ship for the first time?

The first time I saw it, Iris and I had been invited aboard for lunch by the captain of the hospital. CAPT Wilson, who was the chief of surgery, met us when the captain couldn’t, and took us all over the ship. I had been on ships before and knew what they looked like. But the thing I really remember being impressed by was a ward of 48 beds--24 lower bunks and 24 upper bunks. He said, “This is going to be your ward and we’re going to make it into an ICU.” And I thought to myself, “My God, how are we going to give intensive care in an upper bunk?” I remember that impression rather clearly but we figured out that problem fairly quickly once we got underway.

So now you're underway on a modern, well equipped hospital ship. You were state-of-the-art, weren't you?

No. And that was the difficult thing. The *Repose* was not brand new. It was newly recommissioned. It was a World War II C-4 cargo hull with a 400-foot-long crack in one side that it had sustained during a typhoon. It had afterward been very definitely bolstered by a lot of iron plating.

But one of the things we found out--I found out, anyway--was that each of these ships in the Navy had what is called an IOL, an initial outfitting list. Whenever they are recommissioned, they go through that list and the ship is outfitted with everything the ship had when it was first commissioned. This came to me very importantly from Sonny Chenault (Oran Ward Chenault, M.D.), the urologist. On our way to Hawaii, he unpacked the urological clinic equipment, and told me; "Arthur, the only places I've ever seen these things have been in museums. I don't know how to use the damn things."

This made for a great deal of cumshaw as we went across the Pacific and as we got on station. There were a lot of state-of-the-art things on board but it wasn't uniform. The real thing that plagued us . . . We got around all the medical supplies and things like that . . . was the intrinsic working of the ship itself. Its engines were never reliable. Until we went to Yokosuka in July for a month and rebuilt them, they intermittently failed. It had taken us about 5 days to get to Hawaii. We were scheduled for 2 days in Honolulu. We ended up staying 2 weeks. It was a wonderful time for all the rest of us on the medical staff because there were no patients. There was not a thing to do. We went to Fort DeRussy, which was an R&R camp on Waikiki Beach. It was a very pleasant time.

Then we set out across the Pacific. At flank speed, which was about 14 knots, it took us about 6 or 8 weeks to get from Honolulu to Subic Bay in the Philippines. During that voyage the specter of engine failure was there.

It took you 8 weeks?

We didn't arrive until the very first part of March. It took half of January, all of February, and even a few days into March. Because I had been a Berry Planner, my date of rank in the Navy was the day I entered medical school, which happened to be the 23rd of September 1953. So the first thing that happened to me when I got on the ship was that I was promoted from lieutenant to a lieutenant commander, and a lieutenant commander with a fair degree of seniority. This entitled me to a private cabin. It was on the starboard side of the ship's bow, which had a very characteristic "Thump, thump, wham," as the ship was underway and the bow wave washed against it. In the middle of the night while crossing the Pacific, I was awakened I can't tell you how many times by a soft flap, flap, flap. I turned on the light and there was no electricity. I looked out in the hallway and the emergency lights were on and you knew the ship was dead in the water in the middle of the Pacific while they were repairing those engines. The problem plagued us for 7 months until the Navy realized we had to replace them.

We went to Subic and probably arrived off Vietnam about the 11th or 12th of March. Then we made the voyage between Vietnam and Subic probably three or four times in March, April, May, and June taking patients back to the Air Force hospital at Clark Air Force Base. Finally, we just had to go to Japan because it was the only shipyard in the Far East that could accommodate a ship that size. And we rebuilt the engines. Once we did so, we went back out to sea and didn't return to Japan until we changed command in November.

Did they rebuild the engines or replace them?

I think they replaced them. And they also had to do a lot of rebuilding. We stayed in Japan a month. That allowed us to do all sorts of things. It was a 20- or 30-minute ride to Tokyo. Four of us climbed Mt. Fuji. The ophthalmologist and I went to Kyoto. It was a wonderful visit and I enjoyed it.

When you were in Vietnamese waters you operated off what was called I Corps, the northern area of South Vietnam. What were your duties on the ship?

It depended on what happened. I ran the intensive care unit. That was a bit of a logistical organizational problem at first. The first part of the problem was easily solved with Angelica Vitillo, who was the head nurse. She ran a group of 24 nurses and 145 corpsmen assigned to the *Repose*. In the ICU I had a group of six nurses and 19 or 20 corpsmen. Her idea for running a nursing service was to have corpsmen in 2-week rotations in every part of the ship. For all intents and purposes, they had been everywhere and knew nothing about anything. This was not something I could accept, because then ICUs were new and needed experienced personnel. She and I had a long talk. I told her that if she would designate the 19 or 20 corpsmen she wanted in the ICU, I would undertake to train them if she would guarantee them for 1 year.

So we did. We had a stable group of nurses and corpsmen in the ICU. We subjected them to quite intensive training in practical matters such as how to set up chest suction pumps and things like that. Ours were not electrically operated but functioned with gravity. One of the things we learned was that the ship had only been supplied with three suction pumps for chest injuries. When I was on call the very first night we were in Vietnam, we took 55 casualties on board; 11 of them had chest wounds. So we had to make due with a lot of innovative gear and rigging. Nevertheless, we did pretty well. Anyway, that was the first chore.

The second chore was to get rid of the 24 top bunks in the ICU and that was very easy because they were only affixed to stanchions by clamps and you could undo the clamps and put the bunks in the hold and nobody was the wiser. Then I had to get rid of about five or six lower bunks which were permanently fixed to the stanchions, to make room for two fracture beds with traction devices. That required permission from the Bureau of Ships because they were a permanent part of the ship. You can't change a permanent part of a ship without permission of the Bureau of Ships.

Once we had accomplished all the preliminaries, we had a working unit of about 18 beds. The capacity of the ship was 750 patients. Not all of them were surgical patients, so we came out with an effective ratio of beds to the number surgical beds available on the ship.

We really had a fairly peripatetic population. The very seriously injured or the very serious triaged wounded came directly to the ICU from the operating room and occasionally from triage. After we had effected initial treatment, we either transferred them out to the regular surgical wards or back to the United States. I think the average stay in our ICU was 4 ½ to 5 days.

How was the ICU equipped compared to what a stateside hospital of that time would have had?

First off, the beds were abominable. All we had were cots attached to the stanchions. They had no springs or mattresses. They had metal webbing for their springs and about a 4-inch mattress pallet on top of that. So, there was nothing in any of this that looked anything like a hospital bed, excepting the two traction beds. The bunks were far too low on the stanchions for

us to give care easily, but we made do. Beyond that, I could have pretty much whatever I wanted if I made it known that I wanted it. I'll give you one example. I had one young fellow fairly early on who was in septic shock. In the 1960s septic shock was treated with heavy doses of steroids. The morning after his particular attack and recovery, the medical supply officer came to me and said, "Arthur, I want you to know that you've used up the ship's entire supply of hydrocortisone from every ward on one patient in one day."

Not being influenced by this kind of argument, I told him, "This is the reason you're on this ship. Now you go ashore and find me some more." And he did.

Did it help your patient?

The patient lived. What really helps patients with septic shock, however, is not treating the shock, per se, but treating the cause of the sepsis.

Was the Heimlich Chest Valve available at that time?

It was and we didn't use it. We were very careful about sending people on medevacs because they were done in unpressurized airplanes. An individual who had a pneumothorax which had completely cleared could develop a pneumothorax that could not easily be treated in an airplane that was unpressurized. The Heimlich would let air and fluid out but would not let anything in. It's a very convenient valve. We did not transfer anyone we felt at risk.

When one thinks of an ICU, one visualizes monitoring equipment. Did you have that?

Nothing compared to what you have today. The monitoring equipment we had in the ICU for all intents and purposes was the corpsmen. They were dedicated. They took blood pressures and vital signs and observed. For one thing there wasn't any room to put any monitoring equipment anywhere. If we had a patient on a ventilator, we had to find a stanchion and then a clamp to hold it in place. We did have some monitoring equipment; but it was large and bulky and it wasn't as you would see it now--one to one on every bed in the ICU. What we had, we rolled around to whatever patient needed it. But the heart and soul of the ICU care we gave were the corpsmen and nurses. The nurses directed the corpsmen but they did the work.

I know it depended upon what was going on ashore as to how much business you would get. Do you remember any specific occasions when you were overwhelmed with casualties?

The way that I would characterize my year on the *Repose* is: "Three days of sheer terror interspersed with 2 weeks of absolute boredom." This is what would happen, and it would happen by fits and starts depending upon who on the ground got eager and ran into what kind of ambush set by the Viet Cong. It could translate into anywhere from 20 to 30 people who were in all stages of injury. Our process was very easily facilitated by the fact that we had initially set up four triage areas and found that three of them were not useable. The only one we used was the helicopter pad on the stern. A helicopter could deliver four litter patients at a time or nine walking patients. We set up a little station right beside that helicopter pad where the four litter patients could be examined immediately. It took us maybe 5 or 6 minutes to see all four patients and decide where to send them before the next helicopter came in.

We had a backup triage area which was our recovery room. It had 10 beds. We could dispatch the injured to that backup area and they became the ones who were immediately being

prepared for operations. The rest of the patients were dispatched to the various wards or to the ICU. It worked very well simply because we had a limited inflow of patients. We learned to handle that inflow very quickly and get them dispatched throughout the ship where there were open positions for them.

Beside managing the ICU, which was your primary duty, did you also conduct surgery with the others?

Oh, yes. I was one of the surgeons. I'm a general surgeon. There were a few thoracic and cardiovascular surgeons. There was an ophthalmological surgeon. We had some very junior people who would really have been surgical fellows and they were in general surgery. As you know, we had Bill Terry, who was an oral and maxillofacial surgeon. Of the 24 medical officers aboard, I think 9 or 10 of them were in surgical specialties.

Do you remember any specific patients as being unusual cases?

Yes, I remember a few. Actually, the most heart-rending injuries were caused by land mines. The nastiest and most frustrating were the injuries caused by punji sticks. I remember one young man who had stepped on a land mine and lost both legs at the hip joints. His abdomen and chest had been penetrated. Both eyes were lost and he had penetrating wounds of the head. He lasted 18 or 20 hours. I was surprised he lived to get to us. His injuries were so gruesome and we could do little or nothing.

Another patient had been sent from a primary aid station on the beach. There was a note on his chart which contained a reference to the literature. It said, "This patient has been resuscitated according to the latest regulations established by Dr. Tom Shires of Dallas, TX." And they had a citing of the *Journal of the American Association*, such and such a month in 1966. "... at a rate of 10cc's of saline per kilogram body weight per hour."

The guy was a 70kg man and he had received 700cc's of IV fluid for each of the 18 hours that he had been in transit from wherever they saw him to the time he got to us. This was over hydration of a major kind. It did not take into account the fact that resuscitation is something you do until the patient is resuscitated and then you establish maintenance. Fortunately for this kid--he was 18 years old and had wonderful kidneys--he got rid of a great deal of that fluid in the next 24 hours. But he was just one mass of water when he arrived.

I do remember the severity of some of the injuries. And I do think we had some very heartening successes.

Do you recall any of those successes?

Oh, goodness.

It's a little unfair asking you 35 years after the fact.

Unfortunately, the things that stood out for me, were that in Vietnam, we were the reference hospital for correcting mistakes. And there were a lot of mistakes that were made that we had to correct and that annoyed us. One patient I remember had a gunshot wound through his right hip into his abdomen. It had been felt necessary to explore his abdomen on the beach so they did an exploratory laparotomy and found he had a significant gunshot wound of his caecum and the right side of his colon. All of the right side of his colon was removed and an anastomosis was made. He was kept for 4 or 5 days and then sent to us for care.

When he arrived at the triage area--and I happened to be triaging that day--his temperature was 104. I immediately sent him to the ICU and when I went down to see him his temperature was 106. This shouldn't have been for somebody who had an operation like his. I noticed that he was lying on his cot in a rather funny position with his right leg sort of cocked up. I asked him to straighten it out and he said that he couldn't. It turns out that the operating surgeon had drained his abdomen with a Penrose drain where he had taken out the colon. And he decided that the most convenient place to put it was right through the gunshot wound where it entered the body. We got an x-ray of the pelvis and it happened that the gunshot wound passed through his right hip, clipped the femoral head off, and turned it around 180 degrees in the hip socket. So this surgeon had drained a contaminated wound in his abdomen into his hip joint. The hip joint contained about 60cc's of pus; and when we got rid of the pus that night his temperature became manageable.

You say that they had done a resection of his colon?

Yes. The problem they had on the beach was not that they didn't have good doctors; they had insufficient power. If you had an x-ray that came from a forward hospital on the beach and it was a standard 14 x 17-inch x-ray film, probably the central two-thirds of that x-ray film would have been exposed to produce a picture. The full periphery was blank. There was no way anybody looking at that film could appreciate that there was any injury to the hip joint because they didn't see the joint on the film.

We ordered an x-ray and had an immediate answer as to what was going on. It made very clear to me the absolute necessity of a ship like that having superb engines and absolutely superb generators. We had power to spare on the *Repose*. When the ship tied up anywhere, it could hook up to the base where it was and give power to the base if it needed it.

Once you were on the ship and realized its shortcomings, you overcame them by improving the initial product.

It was sort of cute in a way. We stopped at Honolulu and got a very nice invitation from Tripler [Army Hospital] to come visit. The next day we got an invitation not to come visit because everybody who went to Tripler for a visit took anything that wasn't nailed down.

They took things from the hospital to bring back to the ship.

That's right.

So cumshaw was really the name of the game.

Cumshaw helped. One time I and my two senior corpsmen took 47 patients to Clark Field from Subic Bay. I stayed up there a couple of days because a close friend of mine from Minnesota was there on active duty with the Air Force. When I came back these two young corpsmen had used my quarters there as a storage place for things they had procured. I had to call the executive officer of the ship and have him send me a flatbed truck to the airplane to pick up all the material these two kids had assembled. The biggest prize was an electrical Emerson chest suction pump which was on a ward. We had no chest suction pumps at all like it. I did send it back to Clark about 5 weeks before I left the ship in January '67. That's how it worked. There was a tremendous spirit for getting things done. Everybody on that ship felt special in being asked to commission a new hospital on an old ship and doing it from the ground up.

Was there any type of rivalry with your sister ship--USS *Sanctuary*?

It wasn't there. *Sanctuary* didn't come out until after I left.

So you were the only game in town at that time.

That's right.

Where did you go after *Repose*?

When I left the *Repose* on January 9th or 10th of 1967, I went to spend a year in Charleston. I left there and went to the University of Texas Health Science Center in San Antonio, which was not yet completed. So, twice in my life, I've had this unbelievable opportunity to build something from the ground up.

Did you spend the rest of your civilian career there in San Antonio at that facility?

Yes. One appointment--assistant professor all the way through professor emeritus, which I am right now.

What were your titles?

I started in 1967 as an assistant professor and became an associate in 1972 or '73, and a full professor in '74. I retired in 2001 with the title Professor Emeritus.

How do you spend your time now?

Right now I'm going through a series of 78 abstracts for the Western Surgical Association of which I am the current president. I spend 2 days a week in clinic in San Antonio and teaching the students. There's plenty to do between San Antonio and Santa Fe.

It's been 37 years since you were on the *Repose*. Do you ever think about those times much anymore?

Frequently and every now and again I dream about them. I can tell you. It was a band of individuals who got to be very, very close because you didn't go anywhere. No one was more than a hundred feet away from where they worked. And we all lived within 10 feet of one another. We all had a fairly profound respect for one another. One of the things you're not supposed to have aboard Navy ships is alcohol. The whole stock of "medical" alcohol was in my cabin because it was the biggest cabin.

Every day at 5, we had a clinical pathological conference. There we discussed matters and got things done. It was a kind of unifying meeting. Nobody felt they had to come and nobody thought they had to be there every day; a good deal of background work was done there on a daily basis.

I have reflected a lot on that year aboard *Repose* and on items like chance. We replaced and rebuilt the power supply in July 1966. In November 1966 after a change of command at Subic, the incoming captain of the ship, a USNR line captain left Subic at 4:00 pm into the only typhoon we had seen for months in that area. Had we not had the engine refit in July, I sincerely believe the ship would not have weathered that storm. It was a terrifying time for us all.

I want to thank you for spending time with me today. Before we sign off I want to get your address.

The best address to use is our permanent home address.

131 Brittany Dr.
San Antonio, TX 78212-1721